375 Laguna Honda Blvd., San Francisco, CA 94116-1411
Provider ID: 555020
CA00621433, CA00623517, CA00639036, CA00639047, CA00639051, CA00639848, CA00639918, CA0639866, CA00640598, CA00621775, CA00638524
Date of Survey Completed 07/12/2019

F000

This Plan of Correction is the response by Laguna Honda Hospital and Rehabilitation Center ("LHH" or "facility") as required by regulation, to the Statement of Deficiencies and Plan of Correction (CMS-2567) issued by the California Department of Public Health on July 22, 2019, and received by the facility on July 23, 2019, for an Abbreviated Standard Survey conducted for the nine listed case numbers for Facility Reported Incident (FRI) and two listed case numbers for Anonymous Complaint investigations, that concluded on July 12, 2019. The submission of this Plan of Correction does not constitute an admission of the deficiencies listed on the Summary Statement of Deficiencies or an admission to any statements, findings, facts, and conclusions that form the basis of the alleged deficiencies. It should be noted that the CMS-2567 and this Plan of Correction cover some different residents and issues than those discussed by the City and County of San Francisco Department of Public Health ("DPH") on June 28, 2019, and so the number of residents does not always correlate with the numbers publicly discussed by DPH at that time.

The Mission and Vision of LHH underpins the provision of residents with person-centered care in a dignified and respectful environment. LHH structures this environment to maintain or enhance each resident's practicable well-being. In full recognition of the findings contained in the statement of deficiencies the corrective actions described below have been designed to not only address the listed deficiencies but to further the goals of the staff and leadership towards the mission and vision of the organization.



8/13/19 POC accepted.
Marden HFEM I

San Francisco Department of Public Health
Laguna Honda Hospital
and Rehabilitation Center

375 Laguna Honda Blvd., San Francisco, CA 94116-1411
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## RESUBMISSION DOCUMENT

On July 11, 2019 Laguna Honda Hospital and Rehabilitation Center (LHH) was declared to be in an Immediate Jeopardy, due to non-compliance with 5 F-Tags F583, F600, F605 and F607.

1. F-583 Personal Privacy/Confidentiality of Records
2. F-600 Free from Abuse and Neglect
3. F-605 Rights to be Free from Chemical Restraints
4. F-607 Develop/Implement Abuse/Neglect etc. Policies



The statement of Immediate Jeopardy by CDPH included the following findings:

1. The facility's failure to protect 21 of 29 sampled residents from physical, mental, verbal, and sexual abuse, and chemical and physical restraints when:
   a. The facility did not identify incidents of abuse
   b. The facility failed to report incidents of abuse in a timely manner to the California Department of Public Health (The Department) and the responsible parties, and
   c. The facility failed to train staff as mandated reporters to report incidents of abuse directly and within 2 hours to the Department, the Ombudsman, and local law enforcement (refer to F607);

2. 19 of 29 residents were photographed without their consent, three were photographed naked which had the potential to result in physical, mental or psychosocial harm and decline in physical, mental and psychosocial functioning of all residents in the facility (refer to F583);

3. five of 29 residents received medications not prescribed by their physicians that resulted in five residents having life-threatening complications resulting in a significant decline in their physical functioning (refer to F605);

4. four of 29 residents were sexually abused, one of 29 residents were physically restrained, one of 29 residents was kicked by a staff member, and one of 29 residents was verbally demeaned and provoked to make inappropriate sexually explicit statements. These incidents put vulnerable residents at risk for physical, mental, or psychosocial harm and decline in physical, mental and psychosocial functioning (refer toF600).

In relation to these findings, LHH acknowledges CDPH's interpretation of ***42 CFR §483.5. Sexual abuse.*** 42 CFR §483.5 defines "sexual abuse" as "non-consensual sexual contact of any type with a resident," and LHH understands that CDPH is including in its interpretation of this term in the statement of deficiencies both (1) the taking of photographs of a resident showing any exposed breasts, genitals, and/or buttocks and (2) the taking of video recordings of resident(s) in conversations of a sexualized nature. LHH has not found any evidence of sexual physical contact between staff and resident of any type during its investigation but responds to the two other types of sexual abuse included in the statement of deficiencies.

The IJ was lifted on 7/12/19 at 6:36 PM after the facility presented an acceptable Plan of Correction (POC) and the survey team verified the implementation of the POC. The facility staff present were Acting CEO, Director of Quality from GACH 2, CNO, Quality Nursing Manager, and a Quality Nurse.

San Francisco Department of Public Health
Grant Colfax, MD, Director of Health

San Francisco Health Network
Roland Pickens, MHA, FACHE, Director

City and County of San Francisco
London N. Breed
Mayor

Laguna Honda Hospital and Rehabilitation Center
Margaret A. Rykowski RN, MS Acting Executive Administrato



July 12, 2019

The following is an updated removal plan for Immediate Jeopardy related to Intake #: CA 623517, 639051, 639036, 639047, 639848, 639918, 639866, 640598, 621775, 621433, 638524

**A. Assessment of all residents on North 1 and 2:**

1. Upon discovery, each of the identified 23 residents received an immediate assessment and wellbeing check by the Resident Care Team (RCT) and documented in the medical records (February to June 2019).
   *Wellness check for all residents were complete in June using the Nurse Manager tool outlined below. Nurse Managers check in with all 60 residents on every neighborhood each week. This means that all residents housewide are seen on a weekly basis.*
2. Beginning June 2019, the resident check-in process was re-evaluated and the standardized tool was revised, as well as the frequency was increased from monthly to weekly. Now all Laguna Honda Hospital (LHH) residents are assessed weekly by the Nurse Managers (NM) for any signs and symptoms of violations of resident rights and abuse utilizing a standardized tool that includes questions regarding potential abuse and medication safety. Any issues identified during resident interviews are immediately escalated according to the abuse protocol.

**B. Verification that staff identified in incidents were removed from residents' care:**

1. Identified employees have been separated from LHH.
   *LHH believes that all involved staff have been identified through the process of Human Resource investigation, Quality Management investigation. A process where the nurse manager conducts employees supervision and check in with staff members has been implemented, this supervision takes the form of interview, direct observation of staff member undertaking resident care and manager feedback. This process gives staff an opportunity to raise concerns privately and allows the Nurse Manager to observe staff performance.*
   *During the hiring process SFDPH requires 2 references to be obtained for every staff member. One of the required questions on the reference is regarding abuse and neglect allegations.*
   *LHH is in the process of reviewing unusual occurrence and laboratory data for 2016 and 2017 to identify any further urine toxicology results that evidenced drugs not prescribed to the resident in question.*
   *The Nurse Manager check in process with residents described above is ongoing. Nurse Managers will spend time with every resident every week to assess for signs and symptoms of abuse and neglect.*
2. Respective nursing certification boards were notified for all employees involved (May 2019).

**C. Re-train all staff on abuse identification, prevention and reporting:**

1. LHH staff have received training on Abuse Prevention and Reporting, HIPAA, Privacy and Compliance, and Right to be Free from Physical Restraints (February to May 2019).
2. *LHH has created a memo that will be distributed to all staff with a read and sign attestation addressing the staff's roles as mandated reporters and the mechanisms that are available for reporting. This memo will be distributed to staff beginning 7/12/2019, inservice will continue for one week with a goal of 100% staff being educated. At the end of the week (July 19,2019) any outstanding staff on leave, vacation etc. will be educated on return to work*
   LHH will initiate a robust reporting campaign, which educates all staff of their duty as mandated reporters to report any potential incidents of abuse or adverse events (August 15, 2019).
3. *LHH has created a memo that will be distributed to all staff with a read and sign attestation addressing the use of physical restraints. This memo will be distributed to staff beginning 7/12/2019, inservice will continue for one week with a goal of 100% staff being educated. At the end of the week (July 19,2019) any outstanding staff on leave, vacation etc. will be educated on return to work*
   All LHH staff will receive a training on the right to be free from physical and chemical restraints (August 15, 2019).

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4. All LHH staff completed an employee attestation to Information on *What Constitutes Resident Abuse and Timely Reporting Requirements* (April 8, 2019).

**D. Re-train all staff on physical and chemical restraint:**

1. *LHH has created a memo that will be distributed to all staff with a read and sign attestation addressing chemical restraint. This memo will be distributed to staff beginning 7/12/2019, inservice will continue for one week with a goal of 100% staff being educated. At the end of the week (July 19,2019) any outstanding staff on leave, vacation etc. will be educated on return to work*
   All LHH staff will receive a training on the right to be free from physical and chemical restraints (August 15, 2019).

**E. Process for deterring and preventing diversion:**

1. Door monitor was implemented on N1 requiring all visitors and staff to sign-in (February 2019).
   *A "Resident Check In" form has been created that licensed nurses will complete for each resident that returns form leave of absence. This form addresses resident wellbeing, medication use and substance misuse. LHH has a "Clinical Search" policy that addresses when a resident will be physically searched for any contraband materials.*
2. Zone manager was initiated on N1 to increase supervision of residents in the Great Room (February 2019).
3. The nursing department implemented a random audit of the medication pass process. This audit is undertaken on all shifts by nursing leadership (Nurse Managers, Directors and Supervisors) the audit focuses on medication administration, narcotic waste, cycle count, and medication administration documentation for all 13 neighborhoods. *3 medication passes, one cycle count and 2 narcotic wastages are audited per shift/per unit.*
4. A monthly multidisciplinary diversion prevention committee was convened in April 2019 to create a LHH policy and a standardized algorithm for monitoring and investigating potential employee medication diversion. This committee will explore the use of multimodal data collection methods regarding diversion and medication management including but not limited to *Pandora Reports*.
5. A standardized protocol was created for evaluating residents with altered mental status (AMS), somnolence or change in condition (including respiratory depression). This algorithm includes a comprehensive urine toxicology test to identify the presence of non-prescribed medications in their system, (May 17, 2019).
6. LHH Pharmacy implemented a short cycle dispensing model to limit availability of medications to a 48-hour supply in the medication carts beginning April 2019 on a pilot unit and hospital-wide (July 8, 2019).
7. Bar code medication administration will be implemented hospital-wide beginning August 3, 2019.
8. LHH Physicians are undertaking a medication simplification process that will reduce polypharmacy risks for residents.

**F. Educate all staff on the use of cell phones, cameras, video in the facility:**

1. LHH staff received a memo from the Executive Administrator regarding the use of personal cellphones in patient care areas (February 2019).
2. Alert residents were educated by the RCT on the LHH policy regarding staff using their personal cellphone use in patient care areas (February to May 2019).
   *Signage has been placed in all neighborhoods and at the cadet check in station regarding the prohibited nature of photography of residents at LHH without their consent.*
3. During Leadership Forum, training was provided to managers, supervisors and directors on appropriate etiquette regarding use of electronic devices by the Deputy Director of Office of Compliance and Privacy Affairs (June 12, 2019).

If you need more information, please contact me, at (415)759-3053.
Very truly yours,

Geraldine Marlano |Nurse Manager, Quality Management

**F583**

**§ 483.10 Resident rights.**

**(h)Privacy and confidentiality**. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

(3) The resident has a right to secure and confidential personal and medical records.

(i) The resident has the right to refuse the release of personal and medical records except as provided at § 483.70(i)(2) or other applicable federal or state laws.

(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to protect the privacy and confidentiality of 19 residents when photographs and videos were taken and shared by two staff members (CNA 2 & LVN 1). This deficiency reached the level of (K) – a pattern of deficiencies that constitute actual harm that is an immediate jeopardy.

Immediate Corrective Actions:

**See Immediate Jeopardy Removal Plan accepted onsite Friday, July 12, 2019.**

Corrective Actions:

1. **Attachment One (pg. 8-10) details the actions taken for the 19 residents identified in the statement of deficiencies to ensure their individual wellness.**

   Responsible Person:

   **Chief Medical Officer.**

   Completion Date:

   *June 19, 2019.*

2. **CNA 2 and LVN 1 are no longer employed by the City and County of San Francisco. In addition, respective nursing certification and licensing boards have been informed regarding the misconduct discovered. In addition, any other employees of the City and County of San Francisco who were found to have exchanged photos or videos of residents via text message are no longer employed by the City and County of San Francisco.**

   Responsible Person:

   **Chief Nursing Officer.**

   Completion Date:

   **May** *23,* **2019**

**F583 Continued**

3. *To ensure that the facility identified other residents having the potential to have been affected by the same deficient practice,* **Nurse Managers for all Neighborhoods undertook check-ins with all residents to conduct interviews and evaluations regarding breach, abuse or neglect. These interactions also allowed each resident a safe and secure venue to voice any concerns.**
   Responsible Person:
   **Chief Nursing Officer.**
   Completion date:
   **May *31,* 2019.**
   Monitoring:
   **Documentation of all completed check-ins was reviewed by the Chief Nursing Officer to ensure that 100% of residents were seen and assessed. Overall data regarding compliance with this corrective action will be reported to Nursing Quality Improvement Council (NQIC), Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees reporting overall compliance to Joint Conference Committee (JCC), the Governing Body.**

4. **All Laguna Honda staff received a memo via email from the Chief Executive Officer regarding the use of personal cellphones in patient care area. This was followed up by training on Abuse Prevention and Reporting, HIPAA, Privacy and Compliance, and Right to be Free from Physical Restraints that was administered using the electronic learning system (ELM).**
   **Annually all San Francisco Department of Public Health undertake "DPH Annual Compliance and Privacy" Training.**
   Responsible Person
   **Chief Executive Officer.**
   Completion date:
   **February *28,* 2019.**
   Monitoring:
   **Compliance of the in-service education was tracked using the electronic learning system and 100% of staff assigned the modules competed the training. Compliance with all in-service and education will be reported as part of the report from Quality Management to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

5. **Alert residents (as assessed from the residents MDS) were educated by the Resident Care Team (RCT) at community meetings regarding the Laguna Honda policy regarding personal cell phone use in patient care areas. This information was also presented at Residents Council Meeting on *March 1*, 2019.**
   Responsible Person:
   **Chief Nursing Officer.**
   Completion date:
   **May *31,* 2019.**
   Monitoring:
   **This education was evidenced in the Community Meeting and Residents Council Minutes.**

**F583 Continued**

6. **During the Leadership Forum on June 12, 2019, training was provided to managers, supervisors and directors on appropriate etiquette regarding use of electronic devices,** for those staff that did not attend presentation is available for staff to access on the hospital intranet.
   Responsible Person:
   **Deputy Director of Office of Compliance and Privacy Affairs.**
   Completion date:
   **June *15*, 2019.**
   Monitoring:
   **Sign in sheet was reviewed to ensure all staff required to understand this information were present, for those staff that did not attend presentation is available for staff to access.**

7. **Resident Education Flyers regarding cell phone use was placed in each residents' room throughout LHH to reinforce the education provided in the Neighborhood Community Meetings for residents, that visitors and guests of LHH are prohibited from taking photographs and videos of residents without their (or their representatives) consent.**
   Responsible Person:
   **Assistant Hospital Administrator**
   Completion date:
   **May *31*, 2019**
   Monitoring:
   **Placement of flyers will be reviewed as part of the nursing environment of care rounds to ensure that they remain accessible for all residents.**

8. **Signage (Community Education) was placed throughout LHH to ensure that staff, visitors and guests of LHH understand that the recording of videos and photographs of residents without their (or their representative) consent is prohibited.**
   Responsible Person:
   **Manager of Administration.**
   Completion date:
   **August *15*, 2019.**
   Monitoring:
   **Placement of signage will be reviewed as part of the Workplace Safety and Emergency Management quarterly environment of care rounds to ensure they remain in place.**

**Attachment One**

Resident 1
Resident 1 was examined by LHH Physician on 2/7/2019 with no noted injury. Resident 1 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Brother of Resident was informed by telephone 2/19/2019 and letter 2/27/2019*

Resident 2
Resident 2 was examined by LHH Physician on 2/7/2019 with no noted injury. Resident 2 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Conservator of resident was notified by telephone 2/9/2019 and by letter 2/27/2019*

Resident 3
Resident 3 was examined by LHH Physicians on 2/7/2019, and on 4/3/2019 with no noted injury. Resident 3 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Conservator of resident was notified by letter 2/27/2019*

Resident 4
Resident 4 was examined by LHH Physician on 2/7/2019 with no noted injury. Resident 1 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*The resident is his own decision maker and was informed in person 2/19/2019 and by letter 2/27/2019*

Resident 5
Resident 5 was discharge home on 10/1/2018, and his son, who is the surrogate decision maker (SDM), was informed of the incident on 2/19/2019.
*Son of Resident was informed by telephone 2/19/2019 and letter 2/27/2019*

Resident 6
Resident 6 was examined by LHH Physician on 2/7/2019 with no noted injury. Resident 6 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Brother of Resident was informed by telephone 2/19/2019 and letter 2/27/2019*

Resident 7
Resident 7 was examined by LHH Physician on 3/7/2019 with no noted injury. Resident 7 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Son of Resident was informed by telephone 2/25/2019 and letter 2/27/2019*

**Attachment One Continued**

Resident 8
Resident 8 was examined by LHH Physician on 2/21/2019 with no noted injury. Resident 8 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*The resident is her own decision maker and was informed in person 3/1/2019 and by letter 3/15/2019*

Resident 9
Resident 9 was examined by LHH Physician on 2/21/2019 with no noted injury. Resident 9 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Son of Resident was informed by telephone 2/25/2019 and letter 3/15/2019*

Resident 10
Resident 10 was examined by LHH Physician on 2/22/2019 with no noted injury. Resident 10 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Brother of Resident was informed by telephone 2/25/2019 and letter 3/15/2019*

Resident 11
Resident 11 expired on 9/2/2018. The SDM for Resident 11 was informed on 2/25/2019 of the incident.
*Sister in law of resident was informed by telephone 2/25/2019 and the daughter of the resident was informed by letter 3/15/2019*

Resident 12
Resident 12 expired on 11/24/2017. The Public Guardian for Resident 12 was informed on 2/28/2019 of the incident.
*Conservator of resident was notified by telephone 2/28/2019 and by letter 3/15/2019*

Resident 13
Resident 13 was examined by LHH Physician on 3/20/2019 with no noted injury. Resident 13 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Father of resident was notified by telephone 3/21/2019 and 4/1/2019 regarding additional video discovered. Letter sent 4/10/2019*

Resident 14
Resident 14 was examined by LHH Physician on 3/22/2019 with no noted injury. Resident 14 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Decision Maker of resident was notified by telephoned 3/25/2019, 3/26/2019 and 4/1/2019; voicemail message left, spoke with Decision Maker 4/19/2019 and by letter 4/10/2019*

**Attachment One Continued**

Resident 18
Resident 18 was examined by LHH Physician on 5/8/2019 with no noted injury. Resident 18 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*The resident is their own decision maker, were informed in person 5/14/2019 and by letter 5/29/2019*

Resident 19
Resident 19 was examined by LHH Physician on 5/9/2019 with no noted injury. Resident 19 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*The resident is her own decision maker and was informed in person 5/12/2019 and by letter 5/29/2019*

Resident 20
The Public Guardian for Resident 20 was informed on 5/12/2019 regarding the photo taken of resident. Resident 20 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Conservator of resident was notified by telephone 5/12/2019 and by letter 5/29/2019.*

Resident 21
Resident 21's niece, who is her SDM, was informed on 5/12/2019 of the incident. Resident 21 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Conservator of resident was notified by telephone 5/12/2019 and by letter 5/30/2019*

Resident 22
Resident 22 expired on 1/7/2019 due to declining condition from advanced Parkinson's Disease.
*Conservator of resident was notified by letter 6/19/2019*

**F600**

**§ 483.12 Freedom from abuse, neglect, and exploitation.**

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

(a) The facility must -

(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to protect seven residents from verbal, physical and mental abuse.

This deficiency reached the level of (K) – a pattern of deficiencies that constitute actual harm that is an immediate jeopardy.

Immediate Corrective Actions:

**See Immediate Jeopardy Plan accepted onsite Friday, July 12, 2019.**

Corrective Actions:

9. **Attachment Two (pg. 15) details the actions taken for the seven residents identified in the statement of deficiencies to ensure their individual wellness.**

   Responsible Person:

   **Chief Medical Officer**

   Completion Date:

   *March 22, 2019*

10. **Any employees who were found to have participated in misconduct listed in this section are no longer employed by the City and County of San Francisco. In addition, respective nursing certification and licensing boards have been informed regarding the misconduct discovered.**

    Responsible Person:

    **Chief Nursing Officer**

    Completion Date:

    **May *23,* 2019**

11. **As soon as LHH were made aware, the organization reported all incidents of breach of protected health information and alleged abuse immediately to the following people/organizations;**

    - **California Department of Public Health, Licensing and Certification Branch**
    - **Ombudsmen**
    - **Local Law enforcement (San Francisco Sherriff Department)**
    - **The patient, or their surrogate decision maker if conserved**

    Responsible Person:

    **Chief Executive Officer**

    Completion Date:

    **May *10,* 2019** ***for the residents and events described in this CMS 2567.***

**F600 Continued**

12. *To ensure that the facility identified other residents having the potential to have been affected by the same deficient practice,* **Nurse Managers for all Neighborhoods undertook check-ins with all residents to conduct interviews and evaluations regarding breach, abuse or neglect. These interactions also allowed each resident a safe and secure venue to voice any concerns.**
Responsible Person:
**Chief Nursing Officer**
Completion Date:
**May *31,* 2019**
Monitoring:
**Documentation of all completed check-ins was reviewed by the Chief Nursing Officer to ensure that 100% of residents were seen and assessed. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

13. **A memo was created that was circulated to all staff, requiring a read and sign. This memo contained information on what constitutes Physical and Chemical Restraints as forms of abuse; actions to take should they see, hear or suspect abuse in their role as mandated reporters.**
Responsible Person:
**Chief Nursing Officer**
Complete:
**July 12, 2019**
Monitoring:
**Respective Department Managers and Supervisors are responsible for monitoring staff completion of the read and sign. Compliance with all in-service and education will be reported as part of the report from Quality Management regarding overall compliance with the corrective action to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

14. **All Laguna Honda employees will complete two in-service trainings, the first regarding their role as mandated reporters and timely reporting to the California Department of Public Health (CDPH), submission of Ombudsman report (SOC-341). The second in-service contains education regarding identification of abuse, both physical and chemical restraints, abuse prevention, privacy and confidentiality, and resident monitoring and support.**
Responsible Person:
**Nurse Educator**
Completion Date:
**August 15, 2019**
Monitoring:
**Respective Department Managers and Supervisors are responsible for monitoring staff completion of the in-service. Compliance with all in-service and education will be reported as part of the report from Quality Management regarding overall compliance with the corrective action to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

F600 Continued

15. Nurse Managers for all Neighborhoods initiated a standardized tool and process to conduct employee supervision and check in with all nursing staff members, this supervision takes the form of direct observation of staff member undertaking resident care, employee interview to identify any staff burn out, and establish venue if employee have any concerns with regards to any peers or overall feedback, and manager also provides feedback to employee based on care observation. This process gives staff an opportunity to raise concerns privately and allows the Nurse Manager to observe staff performance.

    Responsible Person:

    **Chief Nursing Officer**

    Completion Date:

    **July 15 and ongoing**

    Monitoring:

    **Completion data will be reported to the Chief Nursing Officer. Individual staff members will receive feedback as part of the process. Staff with opportunities to improve their practice will be coached and counselled in real time by the nurse manager. Staff with ongoing performance issues will be managed according to LHH Human Resources processes.**

    **Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

16. *To sustain the detection of other residents having the potential to have been affected by the same deficient practice,* Nurse Managers and other members of the resident care team will continue resident check-ins with each resident on every neighborhood on a weekly basis. This increase from a monthly check-in has been implemented to ensure that residents are: treated with respect; feel safe at Laguna Honda; and provided an additional avenue of communication if they have any concerns regarding the manner in which care has been provided, including any allegations of abuse or neglect, to ensure that their concerns are reported and investigated in a timely manner. Check-in responses will be evaluated. The tool used for this also includes assessment methods for residents unable to communicate. The questions and frequency of the check-in will be adjusted based on data outcomes. Any issues identified during resident interviews are immediately escalated according to the abuse protocol. Nurse Managers and other members of the resident care team are responsible for conducting weekly check-ins and Nursing Program Directors and other department managers are responsible for monitoring compliance.

    Responsible Person:

    **Chief Nursing Officer**

    Complete:

    **June *30,* 2019 and ongoing**

    Monitoring:

    **Data from the "Weekly resident check-in" process will be reported to the NQIC and to PIPS. The Nursing Program Director is responsible for reporting compliance to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC. Nursing Program Directors and the Chief Nursing Officer are responsible for developing on-going improvement action plans to address instances of non-compliance with regulatory requirements.**

**F600 Continued**

17. **Quality Management Nurses, who are members of the Resident Safety and Abuse Prevention Performance Improvement Team will be assigned to conduct a monthly review of the facility reported incidents of allegations of abuse to track facility compliance and timely reporting.**

Responsible Person:

**Quality Management Nurse Manager**

Completion Date:

**Ongoing**

Monitoring:

**Results of the monthly audits will be aggregated and reported to the Resident Safety and Abuse Prevention Performance Improvement Team to identify opportunities for improvement. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

**Attachment Two**

Resident 14
Resident 14 was examined by a LHH Physician on 3/22/2019 with no noted injury. Resident 14 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***Decision Maker of resident was notified by telephoned 3/25/2019, 3/26/2019 and 4/1/2019; voicemail message left, spoke with Decision Maker 4/19/2019 and by letter 4/10/2019***

Resident 13
Resident 13 was examined by a LHH Physician on 3/20/2019 with no noted injury. Resident 13 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***Father of resident was notified by telephone 3/21/2019 and 4/1/2019 regarding additional video discovered. Letter sent 4/10/2019***

Resident 12
Resident 12 expired on 11/24/2017. The Public Guardian for Resident 12 was informed on 2/28/2019 of the incident.
***Conservator of resident was notified by telephone 2/28/2019 and by letter 3/15/2019***

Resident 10
Resident 10 was examined by a LHH Physician on 2/22/2019 with no noted injury. Resident 10 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***Brother of Resident was informed by telephone 2/25/2019 and letter 3/15/2019***

Resident 4
Resident 4 was examined by a LHH Physician on 2/7/2019 with no noted injury. Resident 1 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***The resident is his own decision maker and was informed in person 2/19/2019 and by letter 2/27/2019***

Resident 3
Resident 3 was examined by LHH Physicians on 2/7/2019, and 4/3/2019 with no noted injury. Resident 3 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***Conservator of resident was notified by letter 2/27/2019***

Resident 1
Resident 1 was examined by a LHH Physician on 2/7/2019 with no noted injury. Resident 1 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***Brother of Resident was informed by telephone 2/19/2019 and letter 2/27/2019***

**F605**

**§ 483.10 Resident rights.**

(e)Respect and dignity. The resident has a right to be treated with respect and dignity, including:

(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with § 483.12(a)(2).

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to ensure that residents were free from chemical restraints

This deficiency reached the level of (K) – a pattern of deficiencies that constitute actual harm that is an immediate jeopardy.

Immediate Corrective Actions:

**See Immediate Jeopardy Plan accepted onsite Friday, July 12, 2019.**

Corrective Actions:

18. **Attachment Three (pg. 20) details the actions taken for the five residents identified in the statement of deficiencies to ensure their individual wellness.**

    Responsible Person:

    **Chief Medical Officer**

    Completion Date:

    ***January 15, 2019***

19. **Any employees who were found to have participated in misconduct listed in this section are no longer employed by the City and County of San Francisco. In addition, respective nursing certification boards were informed of the misconduct for all employees involved.**

    Responsible Person:

    **Chief Nursing Officer**

    Completion Date

    **May *23,* 2019**

20. ***To ensure that the facility identified other residents having the potential to have been affected by the same deficient practice,*** **Nurse Managers for all Neighborhoods undertook check-ins with all residents to conduct interviews and evaluations regarding breach, abuse or neglect. These interactions also allowed each resident a safe and secure venue to voice any concerns.**

    Responsible Person:

    **Chief Nursing Officer**

    Completion Date:

    **May *31,* 2019**

    Monitoring:

    **Documentation of all completed check-ins was reviewed by the Chief Nursing Officer to ensure that 100% of residents were seen and assessed. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

**F605 Continued**

21. *All neighborhoods at LHH have a sign-in process for visitors. In addition, LHH has daily scheduled visiting hours throughout the hospital. Sheriff deputies are stationed at the main entrance of the facility. In addition to these security measures a staff member acting as* **door monitor was implemented on North 1 requiring all visitors and staff to sign-in. This is to increase safety and monitoring of visitors coming into North 1** *as all "chemical restraint' events occurred on this unit (attachment four, pg.22, is an example of the North 1 sign in sheet).*

    **Responsible Person:**

    **Nurse Manager N1**

    Completion Date:

    **February** *28,* **2019**

    Monitoring:

    **The log sheets are collected on a weekly basis to ensure that the log is completed. Random observations of the door monitor are being performed to ensure that the staff undertaking the role are fulfilling the specified duties. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

22. **The Nursing Department implemented a random audit that includes medication administration, narcotic waste, cycle count, and medication administration documentation for all 13 neighborhoods across all 3 shifts. Four medication passes, one cycle count and two narcotic wastages are audited per shift/per unit.**

    Responsible Person:

    **Chief Nursing Officer**

    Completion Date:

    **May** *31,* **2019 and ongoing**

    Monitoring:

    **This data will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

23. **A monthly multidisciplinary diversion prevention committee was convened in April 2019 to create a LHH policy and a standardized algorithm for monitoring and investigating potential employee medication diversion. This committee will proactively address concerns, develop policy, review data, provide a process for diversion detection and review events or circumstances where there is suspicion of diversion. As part of this process the committee will explore the use of multimodal data collection methods regarding diversion and medication management including but not limited to Pandora Reports.**

    Responsible Person:

    **Director of Pharmacy**

    Completion Date:

    **April** *26,* **2019 and ongoing.**

    Monitoring:

    **This committee will report to The Pharmacy and Therapeutics Committee (P&T), which reports to PIPS and MEC, and reports to JCC (governing body).**

F605 Continued

24. **A standardized protocol was created for evaluating residents with altered mental status (AMS), somnolence or change in condition (including respiratory depression). This algorithm includes a comprehensive urine toxicology test to identify the presence of non-prescribed medications in resident's system, which in turn has triggers to initiate an in-depth investigation by Quality Management and Nursing and reporting to statutory bodies if in alignment with regulation. Staff were made aware of this new process via a memo sent from the Chief Nursing Officer and Chief Medical Officer.**

Responsible Person:

**Chief Medical Officer**

Completion Date:

**July 18, 2019**

Monitoring:

**At the Nursing Director Daily Huddle and Provider hand-off any change of resident condition that occurred in the preceding shifts are reviewed to ensure that the protocol was initiated when appropriate.**

25. **LHH revised the hospital standards regarding wasting controlled substance to mitigate diversion of narcotic medications, this was communicated to staff using a memo.**
**The facility has updated its policy NPP J-01.0 "Medication Administration" to reflect new process.**

Responsible Person:

**Chief Nursing Officer**

Completion Date:

**July 12, 2019**

Monitoring:

**Compliance is monitored in the random audits of medication practice described above. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**
**The policy will be reviewed and approved by the governing body.**

26. **LHH has implemented a screening process for residents when returning from "out on pass" to identify if a clinical search is necessary to prevent bringing illicit substance(s) or non-prescribed medication(s) to the facility. This will be accomplished by using a standardized tool to ask residents when returning from out-on pass.**

Responsible Person:

**Chief Nursing Officer**

Completion Date:

**August 15, 2019.**

Monitoring:

**The clinical chart will be audited the next business day following the residents return to ensure compliance with this process. Non-compliance will be reported to the nurse manager for follow up. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

F605 Continued

27. **Laguna Honda Pharmacy implemented a short cycle dispensing model to limit availability of medications to 48-hour supply in the medication carts beginning April 2019 on a pilot unit and hospital-wide on July 8, 2019.**
    Responsible Person:
    **Director of Pharmacy**
    Completion Date:
    **July 8, 2019**
28. **Bar code medication administration will be implemented hospital wide at LHH as part of the EPIC electronic health record (EHR) implementation.**
    **The facility has updated its policy NPP J-01.0 "Medication Administration" to reflect new processes.**
    Responsible Person:
    **Director of Pharmacy**
    Completion Date:
    **August 3, 2019.**
    Monitoring:
    **Reports will be generated from the EPIC EHR and compliance will be reported at the P&T Committee post go live. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**
    **The policy will be reviewed and approved by the governing body.**

29. **LHH Physicians are undertaking a medication simplification process that will reduce polypharmacy risks for residents. This process includes eliminating all "partial doses" where possible to reduce error rate in administration and opportunity for diversion.**
    Responsible Person:
    **Chief Medical Officer**
    Completion Date:
    **June *30,* 2019 and Ongoing**
    Monitoring:
    **Reports will be presented at PIPS and MEC regarding the progress of this project. PIPS reports to JCC (Governing Body)**

30. **A memo was created that was circulated to all staff, requiring a read and sign. This memo contained information on what constitutes Physical and Chemical Restraints as forms of abuse; actions to take should they see, hear or suspect abuse and their role as mandated reporters.**
    Responsible Person:
    **Chief Nursing Officer**
    Complete:
    **July 12, 2019**
    Monitoring:
    **Respective Department Managers and Supervisors are responsible for monitoring staff completion of the read and sign. Compliance with all in-service and education will be reported as part of the report from Quality Management regarding overall compliance with the corrective action to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

**Attachment Three**

Resident 2
Resident 2 was immediately seen by a LHH physician on 1/8/2019 and transferred to UCSF Medical Center. He was re-admitted back to Laguna Honda on 1/15/2019 at his baseline. A coach was assigned for all shifts for safety.

Resident 6
On 2/13/2018 Resident 6 was immediately seen by a LHH physician and was transferred to the emergency room for further evaluation and treatment.

Resident 11
Resident 11 expired on 9/2/2018. The SDM for Resident 11 was informed on 2/25/2019 of the incident.

Resident 24
Resident 24 was examined by a LHH Physician on 8/30/2018 and transferred to UCSF Medical Center. Resident 24 was re-admitted to Laguna Honda on 9/10/2018, at her baseline cognitive and functional status. She was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.

Resident 25
Resident 25 was examined by a LHH Physician on 12/25/2018 and was discharged to ZSFG ED for further evaluation. She was then re-admitted to Laguna Honda on 1/4/2019 and was at her baseline in function. Resident 25 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.

**Attachment Four – North one sign in sheet**

**F607**

**§ 483.12 Freedom from abuse, neglect, and exploitation.**

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

(b) The facility must develop and implement written policies and procedures that:

(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

(2) Establish policies and procedures to investigate any such allegations, and

(3) Include training as required at paragraph § 483.95.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to develop and implement its abuse prevention policy and procedure when:

1. The facility did not identify incidents of abuse
2. The facility failed to report incidents of abuse in a timely manner to CDPH and the residents or their responsible person
3. The facility failed to train staff as mandated reporters (reporting directly to CDPH within 2 hours)
4. This deficiency reached the level of (L) – widespread deficiencies that constitute actual harm that is an immediate jeopardy.

Immediate Corrective Actions:

**See Immediate Jeopardy Plan accepted onsite Friday, July 12, 2019.**

Corrective Actions:

**31. Attachment Five (pg. 28-30) details the actions taken for the 21 residents identified in the statement of deficiencies to ensure their individual wellness.**

Responsible Person:

**Chief Medical Officer**

Completion Date:

**May *12*, 2019**

**32. Any employees who were found to have participated in misconduct listed in this section are no longer employed by the City and County of San Francisco. In addition, respective nursing certification boards were informed of the misconduct for all employees involved.**

Responsible Person:

**Chief Nursing Officer**

Completion Date

**May *23*, 2019**

F607 Continued

33. *To ensure that the facility identified other residents having the potential to have been affected by the same deficient practice,* Nurse Managers for all Neighborhoods undertook check-ins with all residents to conduct interviews and evaluations regarding breach, abuse or neglect. These interactions also allowed each resident a safe and secure venue to voice any concerns.

Responsible Person:

Chief Nursing Officer

Completion date:

May *31,* 2019

Monitoring:

Documentation of all completed check-ins was reviewed by the Chief Nursing Officer to ensure that 100% of residents were seen and assessed. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.

34. LHH is creating several strategies that will combine to robustly educate, reinforce and sustain the staff's knowledge and awareness of their role as mandated reporters at LHH. These actions include, but are not limited to;

- "Badge Buddies" (physical cards that hang behind the ID badges that each staff member is required to wear at all times) are being created with the reporting requirements to State Agencies, Ombudsmen, Law enforcement and Nursing Operations to provide a quick reference. These badge buddies will include the relevant telephone numbers.
- In-services with accompanying post-tests. This training includes procedures and information as mandated reporters to report incidents of abuse directly and within 2 hours to CDPH, the Ombudsman, local law enforcement (when applicable), and Nursing Operations. This in-service will include identification and prevention of abuse, resident monitoring and support.
- Additional posters for all neighborhoods with reporting guidelines and contact information for State Agencies, Ombudsmen and Law Enforcement and Nursing Operations.
- A written communication from the Chief Executive Officer describing the chain of events that occurred leading up to the discovery of these cases of abuse and an overall summary of all the actions undertaken by LHH to correct the issues identified.
- Case Presentations for staff on all shifts in each neighborhood, to emphasize, using a scenario-based approach, and the role of mandated reporter.

Responsible Person:

Chief Nursing Officer

Completion Date:

August 15, 2019

Monitoring:

Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.

F607 Continued

35. A memo was created that was circulated to all staff, requiring a read and sign. This memo contains information on what constitutes Physical and Chemical Restraints as forms of abuse, lists actions staff should take if they see, hear or suspect abuse, and describes their role as mandated reporters.

Responsible Person:

**Chief Nursing Officer**

Complete:

**July 12, 2019**

Monitoring:

**Respective Department Managers and Supervisors are responsible for monitoring staff completion of the read and sign. Compliance with all in-service and education will be reported as part of the report from Quality Management regarding overall compliance with the corrective action to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

36. **The facility has further revised its policy and procedure LHHPP 22-01 "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response", and will be reviewed by the Hospital Executive Committee (HEC). The revisions included the steps to be taken as mandated reporter on discovery of apparent abuse and neglect and how to report suspicion of, or incidents of, abuse anonymously in a timely manner.**
**These changes are included in the content of the in-service described above.**

Responsible Person:

**Manager of Administration**

Completion Date:

**August 15, 2019**

Monitoring:

**The policy will be reviewed and approved by the governing body.**

37. **The Quality Management Department at LHH is currently being assessed and potentially reorganized to create standard work regarding the investigation, assessment and reporting of adverse events, abuse, and other unusual occurrences to state and federal agencies. This reorganization will also include education and standardization regarding process across the wider San Francisco Health Network.**

Responsible Person:

**Chief Executive Officer**

Complete:

**Ongoing**

Monitoring:

**Changes to structure and function will be reported at PIPS and JCC.**

F607 Continued

38. LHH undertook a survey with all staff in February of this year using an external vendor regarding employee engagement, and some of these questions were directed towards the culture of safety. These results are currently being analyzed, and LHH Leadership will begin a process of formulating action plans to address any opportunities identified in this survey in October 2019. LHH plans to begin measuring the Culture of Safety on a biennial basis moving forward, using an evidence-based tool such as the one available from the Agency for Healthcare Research and Quality (ARHQ). Following analysis of these results, in collaboration with managers, supervisors and frontline staff, action plans will be formulated, again in collaboration with the same staff groups, to address opportunities that are identified regarding LHH Culture of Safety

Responsible Person:

**Chief Executive Officer**

Complete:

**Ongoing**

Monitoring:

**Changes to structure and function will be reported at PIPS and JCC.**

39. *To sustain the detection of other residents having the potential to have been affected by the same deficient practice,* Nurse Managers and other members of the resident care team will continue resident check-ins with each resident on every neighborhood on a weekly basis. This increase from a monthly check-in has been implemented to ensure that residents are: treated with respect; feel safe at Laguna Honda; and provided an additional avenue of communication if they have any concerns regarding the manner in which care has been provided, including any allegations of abuse or neglect, to ensure that their concerns are reported and investigated in a timely manner. Check-in responses will be evaluated. The tool used for this also includes assessment methods for residents unable to communicate. The questions and frequency of the check-in will be adjusted based on data outcomes. Any issues identified during resident interviews are immediately escalated according to the abuse protocol. Nurse Managers and other members of the resident care team are responsible for conducting weekly check-ins and Nursing Program Directors and other department managers are responsible for monitoring compliance.

Responsible Person:

**Chief Nursing Officer**

Complete:

**June *30,* 2019 and ongoing**

Monitoring:

**Data from the "Weekly resident check-in" process will be reported to the NQIC and to PIPS. The Nursing Program Director is responsible for reporting compliance to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC. Nursing Program Directors and the Chief Nursing Officer are responsible for developing on-going improvement action plans to address instances of non-compliance with regulatory requirements.**

**F607 Continued**

40. **Quality Management Nurses, who are members of the Resident Safety and Abuse Prevention Performance Improvement Team will be assigned to conduct a monthly review of the facility reported incidents of allegations of abuse to track facility compliance and timely reporting.**

Responsible Person:

**Quality Management Nurse Manager**

Completion Date:

**Ongoing**

Monitoring:

**Results of the monthly audits will be aggregated and reported to the Resident Safety and Abuse Prevention Performance Improvement Team to identify opportunities for improvement. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

Laguna Honda Hospital
and Rehabilitation Center

375 Laguna Honda Blvd., San Francisco, CA 94116-1411
Provider ID: 555020
CA00621433, CA00623517, CA00639036, CA00639047, CA00639051, CA00639848, CA00639918, CA0639866, CA00640598, CA00621775, CA00638524
Date of Survey Completed 07/12/2019

**RESUBMISSION DOCUMENT**

**Attachment Five**

Resident 1
Resident 1 was examined by a LHH Physician on 2/7/2019 with no noted injury. Resident 1 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***Brother of Resident was informed by telephone 2/19/2019 and letter 2/27/2019***

Resident 2
Resident 2 was examined by a LHH Physician on 2/7/2019 with no noted injury. Resident 2 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***Conservator of resident was notified by telephone 2/9/2019 and by letter 2/27/2019***

Resident 3
Resident 3 was examined by a LHH Physician on 2/7/2019 and on 4/3/2019 with no noted injury. Resident 3 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***Conservator of resident was notified by letter 2/27/2019***

Resident 4
Resident 4 was examined by a LHH Physician on 2/7/2019 with no noted injury. Resident 1 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***The resident is his own decision maker and was informed in person 2/19/2019 and by letter 2/27/2019***

Resident 5
Resident 5 was discharge home on 10/1/2018, and his son, who is the SDM, was informed on the incident on 2/19/2019.
***Son of Resident was informed by telephone 2/19/2019 and letter 2/27/2019***

Resident 6
Resident 6 was examined by LHH Physician on 2/7/2019 with no noted injury. Resident 6 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***Brother of Resident was informed by telephone 2/19/2019 and letter 2/27/2019***

Resident 7
Resident 7 was examined by LHH Physician on 3/7/2019 with no noted injury. Resident 7 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
***Son of Resident was informed by telephone 2/25/2019 and letter 2/27/2019***

**Attachment Five Continued**

Resident 8
Resident 8 was examined by LHH Physician on 2/21/2019 with no noted injury. Resident 8 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*The resident is her own decision maker and was informed in person 3/1/2019 and by letter 3/15/2019*

Resident 9
Resident 9 was examined by LHH Physician on 2/21/2019 with no noted injury. Resident 9 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Son of Resident was informed by telephone 2/25/2019 and letter 3/15/2019*

Resident 10
Resident 10 was examined by LHH Physician on 2/22/2019 with no noted injury. Resident 10 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Brother of Resident was informed by telephone 2/25/2019 and letter 3/15/2019*

Resident 11
Resident 11 expired on 9/2/2018. The SDM for Resident 11 was informed on 2/25/2019 of the incident.
*Sister in law of resident was informed by telephone 2/25/2019 and the daughter of the resident was informed by letter 3/15/2019*

Resident 12
Resident 12 expired on 11/24/2017. The Public Guardian for Resident 12 was informed on 2/28/2019 of the incident.
*Conservator of resident was notified by telephone 2/28/2019 and by letter 3/15/2019*

Resident 13
Resident 13 was examined by LHH Physician on 3/20/2019 with no noted injury. Resident 13 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Father of resident was notified by telephone 3/21/2019 and 4/1/2019 regarding additional video discovered. Letter sent 4/10/2019*

Resident 14
Resident 14 was examined by LHH Physician on 3/22/2019 with no noted injury. Resident 14 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Decision Maker of resident was notified by telephoned 3/25/2019, 3/26/2019 and 4/1/2019; voicemail message left, spoke with Decision Maker 4/19/2019 and by letter 4/10/2019*

**Attachment Five Continued**

Resident 18
Resident 18 was examined by LHH Physician on 5/8/2019 with no noted injury. Resident 18 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*The resident is their own decision maker, were informed in person 5/14/2019 and by letter 5/29/2019*

Resident 19
Resident 19 was examined by LHH Physician on 5/9/2019 with no noted injury. Resident 19 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*The resident is her own decision maker and was informed in person 5/12/2019 and by letter 5/29/2019*

Resident 20
The Public Guardian for Resident 20 was informed on 5/12/2019 regarding the photo taken of resident. Resident 20 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Conservator of resident was notified by telephone 5/12/2019 and by letter 5/29/2019.*

Resident 21
Resident 21's niece, who is her SDM, was informed on 5/12/2019 of the incident. Resident 21 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*Conservator of resident was notified by telephone 5/12/2019 and by letter 5/30/2019*

Resident 22
Resident 22 expired on 1/7/2019 due to declining condition from advanced Parkinson's Disease.
*Conservator of resident was notified by letter 6/19/2019*

Resident 24
Resident 24 was examined by a LHH Physician on 8/30/2018. Resident 24 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*The resident is her own decision maker and was informed 8/30/2019 and the resident's niece was informed 8/31/2019 regarding the positive urine toxicology result.*

Resident 25
Resident 25 was examined by a LHH Physician on 12/25/2018. Resident 25 was provided with psychosocial support by the RCT and there have been no noted changes in mood, function and activities.
*The resident is her own decision maker and was informed 12/25/2019 of the positive urine toxicology result.*

**F689**

**§ 483.25 Quality of care.**

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following:

**(d) Accidents**. The facility must ensure that -

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to ensure the safety for four of four residents
by not monitoring/supervising effectively.
This deficiency reached the level of (H) – a pattern of deficiencies that constitute actual harm that is not an immediate jeopardy.

Immediate Corrective Actions:

**See Immediate Jeopardy Plan accepted onsite Friday, July 12, 2019.**

Corrective Actions:

41. **Attachment Six (pg. 35) details the actions taken for the four residents identified in the statement of deficiencies to ensure their individual wellness.**

Responsible Person:

**Chief Medical Officer**

Completion Date:

**May 2019**

Corrective Actions:

42. *To ensure that the facility identified other residents having the potential to have been affected by the same deficient practice,* **Charge nurses will use the standardized protocol for evaluating residents with altered mental status (AMS), somnolence or change in condition (including respiratory depression) on their neighborhoods, as described in corrective actions for TAG 605. Staff were made aware of this new process via a memo sent from the Chief Nursing Officer and Chief Medical Officer.**

Responsible Person:

**Chief Nursing Officer**

Completion Date:

**July 26, 2019**

Monitoring:

**At the Nursing Director Daily Huddle and Provider hand off any change of resident condition that occurred in the preceding shifts are reviewed to ensure that he protocol was imitated when appropriate.**

F689 Continued

43. **Quality Management Nurses, who are members of the Resident Safety and Abuse Prevention Performance Improvement Team will be assigned to conduct a monthly review of the facility reported incidents related to allegations of abuse to track facility compliance and timely reporting.**

Responsible Person:

**Quality Management Nurse Manager**

Completion Date:

**Ongoing**

Monitoring:

**Results of the monthly audits will be aggregated and reported to the Resident Safety and Abuse Prevention Performance Improvement Team to identify opportunities for improvement. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

44. *To ensure that the facility identified other residents having the potential to have been affected by the same deficient practice, Charge Nurses will review all residents on each neighborhood, any resident requiring the use of a mechanical lift will have their care plan updated to reflect the change in policy and practice to use 2 staff at all times.*

*Responsible Person:*

*Chief Nursing Officer*

*Completion Date:*

*July 26, 2019*

45. **The facility updated its policy and procedure NPP D6-01.1 "Battery Operated Lift Transfer" to require all types of mechanical lifts to have two staff members during use, for resident and staff safety.**

Responsible Person:

**Chief Nursing Officer**

Completion Date:

**August 15, 2019**

Monitoring:

**The policy will be reviewed and approved by the governing body.**

**Observations of clinical practice of individual members of the team using the lift equipment will be incorporated into the "Employee Supervision" process described in the corrective actions for Tag F600.**

**Completion data will be reported to the Chief Nursing Officer. Individual staff members will receive feedback as part of the process. Staff with opportunities to improve their practice will be coached and counselled in real time by the nurse manager. Staff with ongoing performance issues will be managed according to LHH Human Resources processes. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.**

F689 Continued

46. **New protocol to be implemented regarding the screening residents when returning from a pass to identify if a clinical search is necessary to prevent the bringing of illicit substance(s) or non-prescribed medication(s) to the facility. This will be accomplished by using a standardized tool to ask residents when returning from a pass** *(attachment seven on page 37). When a resident returns from being "out on pass" the licensed nurse assigned to that resident will use the tool to ask the resident questions and complete an assessment of them. Using this standardized method of assessing each resident balances the rights of the resident and the safety and security of the other residents and staff if there is reasonable suspicion or evidence that the resident may bring items into the facility that may cause risk to themselves or others.*

Responsible Person:

**Chief Nursing Officer**

Completion Date:

**August 15, 2019.**

Monitoring:

**Data regarding compliance will be reported to the NQIC, PIPS and MEC. The Quality Management Nurse Manager is responsible for reporting compliance to NQIC and to the SNF PIPS. Nursing Program Directors and the Chief Nursing Officer are responsible for developing on-going improvement action plans to address instances of non-compliance with regulatory requirements.**

47. **New protocol has been developed regarding appropriate supervision of resident visiting one-another from different neighborhoods. These visits will occur in the Great Room of each neighborhood and not in residents room.**

Responsible Person:

**Chief Nursing Officer**

Completion Date:

**August 15, 2019**

Monitoring:

**Data regarding compliance will be reported to the NQIC, PIPS and MEC. The Quality Management Nurse Manager is responsible for reporting compliance to NQIC and to the SNF PIPS. Nursing Program Directors and the Chief Nursing Officer are responsible for developing on-going improvement action plans to address instances of non-compliance with regulatory requirements.**

48. **Nursing Staff will complete an in-service. This training includes procedure and information on screening residents upon return from a pass and when to initiate a clinical search; standard procedure when a resident visits another resident; and requiring all types of mechanical lifts to have two staff members during use.**

    Responsible Person:

    **Nurse Educator**

    Completion Date:

    **August 15, 2019**

    Monitoring:

    **Respective Department Managers and Supervisors are responsible for monitoring staff completion of the in-service. Compliance with all in-service and education will be reported as part of the report from Quality Management regarding overall compliance with the corrective action to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC. The policy will be reviewed and approved by the governing body.**

49. **Laguna Honda policy and procedure LHHPP 22-12 "Clinical Search Protocol" and LHHPP 20-06 "Leave of Absence (Out on Pass)" will be reviewed and revised by the Hospital Executive Committee (HEC) on August 6, 2019 to reflect the protocol for screening resident's when returning from out on pass.**

    Responsible Person:

    **Manager of Administration**

    Completion Date:

    **August 15, 2019**

    Monitoring:

    **The policy will be reviewed and approved by the governing body.**

**Attachment Six**

Resident 26
A clinical search was completed for Resident 26 on 5/30/2019 and there was no illicit substance or non-prescribed medication found. Resident 26 was also relocated to another room on Pavilion SNF PMS 15A to separate him from the roommate. The primary physician also evaluated Resident 26 on 5/29/2019, 5/30/2019 and 6/3/2019. There has been no further incident of positive urine toxicology. Resident 26 has improved significantly with his activities of daily living (ADL's) in more than one area that includes, bed mobility, transfer, walking and locomotion). Resident 26 was successfully discharged home on 6/18/2019.

Resident 27
Resident 27 was examined by a physician on 5/21/2019, and his condition did not warrant any discharge to acute hospital level of care. The RCT met with Resident 26 and a behavioral agreement was initiated on 6/4/2019. Resident 27 was also referred to the Substance Treatment and Recovery Services (STARS) program. Random clinical searches and urine toxicology test will also be performed.

Resident 28
Resident 28 was referred to the STARS program. He was also referred to psychiatry for support and was seen on 5/31/2019, 6/4/2019, 6/26/2019, 6/28/2019 and 6/29/2019. The RCT met with Resident 28 on 5/30/2019, and his plan of care was revised to include random urine toxicology test and clinical search. Resident 28 was also counseled and reviewed the facility policy on illicit substance.

Resident 29
Resident 29 was examined by physician on 5/28/2019 when incident occurred. There was no negative finding from the physician examination. Resident was monitored by RCT to identify any negative impact from this incident. Noted to have pain on 5/29/2019 and resident was seen by attending MD for pain management, no injury noted from examination. Resident care plan was revised to ensure 2 staff present when care is being provided. CNA 5 was counseled on the policy and procedure on the safe use of mechanical lift.

**Attachment Seven – Resident Screening Tool for returning form Pass**